

Accredited Medical Equipment Providers of America

20815 N.E. 16th Avenue – Suite B-32 • Miami, FL 33179

(305) 654-5957 • Fax 1-866-322-2060 www.amepa.us



2009 MEMBERSHIP APPLICATION:

Date: _____

Please fax the application with your Credit Card information or send a check.

MEMEBERSHIP FEE - \$500 Per Company / Per Year

\$50 Discount for members of VGM or AAHomecare

COMPANY INFORMATION

Legal Name: _____

DBA: _____

Contact/Position: _____

Address: _____

City: _____ Zip: _____ State: _____ Yr Established: _____ # of Employees _____

Office # _____ Fax# _____ Cell# _____

Email: _____ Alt Email: _____

Residential Zip Code of Owner/Managers: _____ Referred By: _____

Accredited By: _____ Date of Accreditation: _____

Non-Accredited providers are Associate Members. Do you plan on becoming Accredited? _____

Does your company belong to a State/Regional Association? (Name): _____

Associations/GPOs: VGM AA Homecare State Assoc. _____

Name of Billing Software: _____

Name of Billing Service (Contact) _____ Tel#: _____

List your top vendors in DME: _____

DME provided by your company (Circle All) APMs • BiPAP • CPAP • Complex Rehab • Enteral • Hospital Beds
Homefill Oxygen • Liquid Oxygen • Nebulizer Medications • Power Wheelchairs • Trache Patients • Ventilators

NOTE: The above is privileged information. It will not be released or used for solicitation

PAYMENT INFORMATION

Full Payment is greatly Appreciated

50% payment is attached. My signature allows the initial charge to my credit card & in 6 months.

Amount to Charge: \$ _____ Signature: _____ Date: _____

Credit Card M/C VISA AMEX - Card # _____

Exp Date _____ V-Code (3 digit - 4 digit for AMEX) _____ Billing Zip Code: _____